

**PRE-APPROVAL VISIT
TO BE CONDUCTED BY SPONSOR**

1. Center Name _____

Address _____

Telephone _____ Director _____

Type of Center ___CCP___PCC___OSH___Head Start___At Risk___Homeless___ADC___Title XIX (ADC)

2. Licensed Capacity _____ Expiration Date ____/____/____

3. Total number of participants enrolled _____ Number in attendance _____

4. Indicate type of meals to be claimed for reimbursement.

	Breakfast	AM Snack	Lunch	PM Snack	Supper	Late Night Snack
Time of Meal Service						
Estimated Number to be Served						

5. If claiming more than 2 meals and 1 snack OR 2 snacks and 1 meal, explain procedure to ensure correct meal count.

6. How will meals be provided? _____Self-Preparation _____Contract _____Central Kitchen _____Other

7. Has center staff been trained according to USDA meal pattern requirements? ____Yes ____ No

8. Is an enrollment form on file for each participant? ____ Yes ____ No

9. Will family size and income information be obtained for each participant? ____Yes ____No

10. Have record keeping requirements been explained and discussed with the center director? ____Yes ____No

11. List names of personnel responsible for CACFP Administration and Food Service. Include specific duties assigned to each.

Administration	Duties
Food Service	Duties

12. Has racial/ethnic information been collected on the area to be served? ____Yes ____No

_____/_____/_____
Signature of Center Director Date Authorized Sponsor Representative _____/_____/_____
Date